

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043905

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

6099

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED DEC - 2 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 5 Months		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 12819 State Line		d. STREET ADDRESS (If outside, give location) 12819 State Line	
3. NAME OF DECEASED (Type or print) - MILDRED B. FARRIS		4. DATE OF DEATH Month November Day 8, Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-17-1895
9. AGE (last birthday) 68		IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager- Carol Sager Associates		10b. KIND OF BUSINESS OR INDUSTRY Whitesville, Missouri	
11. BIRTHPLACE (City and state or country) U. S. A.		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME Henry L. Farris		13b. MOTHER'S MAIDEN NAME Emma Coakley	
14. NAME OF HUSBAND OR WIFE - - -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Francis Farris Address Kansas City, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypostatic pneumonia DUE TO (c) Metastatic cancer, chest, lung, right		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 72 hours March 1963	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from June 1963 to Nov. 8-63 and last saw her alive on Nov 8-63. Death occurred at 3 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Sam D. Hooper, M.D.		22b. ADDRESS 12921 Grandview Rd. Grandview, Mo.	
22c. DATE SIGNED Nov 8-63		22d. LOCATION (City, town, or county) (State) Savanah, Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-8-63	23c. NAME OF CEMETERY OR CREMATORY Savanah Cemetery	
23d. FUNERAL DIRECTOR Freeman Mortuary		23e. ADDRESS Kansas City, Mo.	
24. DATE RECD. BY LOCAL REG. 11-9-63		25. REGISTRAR'S SIGNATURE Bessie Smith	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Sam D. Hooper

USE BLACK INK
OR
TYPEWRITER RIBBON

601510-101

RECEIVED

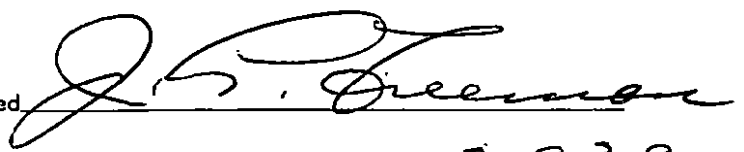
12921
MR. Sams, H/O EDER
Shandlauer, PA.

STATEMENT BY LICENSED EMBALMER

0-09

I hereby certify that, the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 2939
P. O. Address F. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.